

West Virginia Department of Health and Human Resources  
Office of Environmental Health Services  
Infectious Medical Waste Program



Infectious Medical Waste Management Facility Application for Permit

Application for a \_\_\_\_\_ New \_\_\_\_\_ Renewal permit. Current IMW Permit No. \_\_\_\_\_

Owner \_\_\_\_\_ SS # \_\_\_\_\_  
(SS# not required for corporations or government entities)

Agent \_\_\_\_\_ SS # \_\_\_\_\_

Name of Facility \_\_\_\_\_ FEIN \_\_\_\_\_

Type of Facility \_\_\_\_\_ Units \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Location \_\_\_\_\_

Telephone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

Contact Person \_\_\_\_\_ Title \_\_\_\_\_

Email address \_\_\_\_\_

Does Facility Treat Infectious Medical Waste On-Site \_\_\_\_\_ Yes \_\_\_\_\_ No.

If yes, what method is used? \_\_\_\_\_ Incineration \_\_\_\_\_ Autoclaving \_\_\_\_\_ Other (explain on attached sheet)

I hereby certify that I have reviewed the West Virginia Infectious Medical Waste Rule, 64CSR56, and that this facility will comply with the requirements therein. The rule is available at: [www.wvsos.com/csr/verify.asp?TitleSeries=64-56](http://www.wvsos.com/csr/verify.asp?TitleSeries=64-56)

\_\_\_\_\_  
Date of Application

\_\_\_\_\_  
Signature of Applicant  
( ) Owner ( ) Agent

Checks should be made payable to the **WV Bureau for Public Health.**

Applicants for new permits or those with major changes in their management plan must attach two (2) copies of the infectious medical waste management plan. Fee schedule on reverse.

Mail completed application to: Office of Environmental Health Services - Infectious Medical Waste Program  
Capitol & Washington Streets  
1 Davis Square, Suite 200  
Charleston WV 25301-1798

Telephone No. (304) 558-6783, Fax No. (304) 558-1071, E-mail: [dthornton@wvdhhr.org](mailto:dthornton@wvdhhr.org)

*For Department Use Only*

Date application with fee received \_\_\_\_\_

Amount paid \$ \_\_\_\_\_

Date reviewed \_\_\_\_\_ by \_\_\_\_\_

Check No. \_\_\_\_\_

Date approved \_\_\_\_\_ by \_\_\_\_\_

Date of check \_\_\_\_\_

Date denied \_\_\_\_\_ by \_\_\_\_\_

Application No. \_\_\_\_\_

Date Issued \_\_\_\_\_

FEIN check \_\_\_\_\_

Date Expires \_\_\_\_\_ Permit Number \_\_\_\_\_